



HEALTH AND COUNSELING INFORMATION

GENERAL INFORMATION

Name: _____
Last First Middle Former

NUID#: _____ Date of Birth: ___/___/____ Gender: ___M ___F Telephone: (____) ___-_____

Person to notify in case of emergency:

Name: _____ Family Physician: _____

Address: _____ Address: _____

Telephone: (____) ___-_____

Telephone: (____) ___-_____

INSURANCE INFORMATION

COPY OF INSURANCE CARD CAN REPLACE THIS INFORMATION

Insurance Company _____ Policy Number _____

IMMUNIZATION HISTORY

All entering students must show a valid immunization record (2 shots) for measles, mumps, and rubella (MMR). It is recommended that first year students living in College housing receive a meningococcal vaccination, but it is not required.

Important information for International Students: A tuberculosis test may be required. Please contact the Admissions office to determine if a test is required for your home country.

How to submit your immunization records:

1. Upload immunization records through your myPSC account (preferred method)
 - a. Log in to myPSC account
 - b. Under Student Quick Links, select "Upload Items to Admissions"
2. Email immunization records to admissions@peru.edu
3. Fax immunization records to 402-872-2296
4. Mail immunization records to Peru State Admissions: 600 Hoyt Street; PO Box 10, Peru, NE 68421

CONSENT FOR TREATMENT

I authorize Peru State College, Peru State Health Center and Counseling Services to provide medical and or/mental care to:

Name: _____ Date of Birth ___/___/____

In case of mental health concern, illness, or injury, permission is hereby granted to treat the above named student as deemed necessary by the staff of the Peru State College Health Center, their designated personnel, and/or the staff of the Peru State Counseling Center. Services may include but are not limited to routine and emergency medical services (including examinations; laboratory, radiologic and other testing vaccinations; minor surgical procedures; prescription and other treatments), and mental health services.

I understand that, in the case of a minor child, should said minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated. I further understand that, according to Nebraska state law, that once an individual reaches the age of 19, parental consent for treatment is no longer required. Parent or guardian consent is not legally required for minors who seek medical diagnosis and treatment for sexually transmitted diseases.

To the best of my knowledge, the above information is accurate. I understand the information I provided will be used to assist medical personnel in case of emergency.

SIGNATURE OF STUDENT, DATE

SIGNATURE OF PARENT OR GUARDIAN (IF STUDENT IS LESS THAN 19 YEARS OF AGE), DATE